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# Thoughts in a Disaster

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"What is your deployment status?" It was the second week of my third year Psychiatry clerkship when my phone rang and I heard the excited and nervous voice of my old ambulance partner. Instinctively I answered "available," and 72 hours later I was on a plane to Haiti. Immediately on arrival, the fragility of the human mind was recognized. Tempting as it is to draw lines between the providers and admitted inpatients, the reality is that their separation is merely by a thin line of circumstance. This is not always readily apparent, but after a few conversations most patients can be related to the provider. Many have had difficult lives, others succumbed to intangible psychoses or anxieties, and even more have both.

In American inpatient units, patients are well defined and manageable. Spending time with each during the day and exploring their history is beneficial to both the interviewer and interviewee. By hearing about the patient's situation, their opinions, and events leading up to the admission, both people gain an insight and understanding that neither could have achieved alone. When in a crisis, putting the situation into words requires reflection and organization . This type of emotion and thought management is helpful not just in resolving the current crisis, but also in preventing future ones. While medication therapy is important and proven, as are modalities such as electroconvulsive therapy (ECT), psychiatric care providers must remember that they are adjunct to the simpler treatment of conversation.

These observations were made during the first few days of my Psychiatry clerkship, before the Haitian Earthquake occurred on January 12th ,2010. During this time I discovered that the dialogue was the most enjoyable and satisfying part of psychiatric treatment. Medications, while often effective, did not provide the intimacy with a patient's psyche needed to truly appreciate his or her condition. By relating to each patient through detailed interviews, I was able to detect subtle changes in their condition and determine whether or not medications were working. Here in the United States, healthcare providers have that luxury, the ability to utilize different therapies in conjunction with each other. Here, we have the diagnostic tools, lab tests, imaging, medication trials, and most importantly, the luxuries of time and a controlled environment. In a disaster zone none of these exist: it is only the provider and the patients.

Earthquakes are raging and indiscriminate events of power and destruction. Our self imposed societal boundaries and divisions are mocked by the shockwaves rippling through the land. Palaces and shanties fall together; ministers and criminals are injured and killed simultaneously. It is within this context of total devastation that all members of a population experience the same emotions: shock, fear, misery, and hope. Catastrophe is the great equalizer, but it also becomes the greatest unifier.

The first unification is with the shock and fear. Many don't understand how such a horrible thing could occur. As the magnitude of the earthquake was revealed, in this case over 200,000 killed, one million orphaned, and up to three million homeless, the affected become unified in misery. It is at this point that the role of psychiatry becomes evident and the skill of exploring feelings and emotions becomes life-saving.

I was guilty of underestimating psychiatry, even upon my arrival in Port-au-Prince. Preparations were for treatment of traumatic injuries: fracture reductions, wound debriding, amputations, and suturing, as well as for medical complaints such as respiratory and wound infections, fevers, and infectious diseases. On the evening of the first full day of wandering though internally displaced persons (IDP) camps and treating hundreds of victims, my reflections surprised me. Sitting against a crumbled stone wall watching a person I had just comforted dig his family out of the pile that was once his house, I realized that it was those discussions with the affected that helped more than any physical

treatment administered. This man, who had escaped rubble yet was crushed on the inside, came to me with hopelessness. I listened to his story, sympathized with him, and steadied him while he took this load off of his back. Survivor's guilt had left him directionless; being told that it was not his fault was a sort of forgiveness that he needed to go on. Suddenly I realized that the most common injury in Haiti was emotional trauma, and the most important treatment that our team brought was our capacity for listening.

The patients treated that first day had a wide variety of injuries and medical complaints. But all had the same need for support. It was very different from the inpatient ward only a four hour flight away in New York City, yet the interpersonal connections were the same. Those first few weeks of experience with the various patients had built a foundation of skill that I was unaware of until then. We didn't have the diversity of conditions like bipolar and schizophrenia, and there was no time to explore personality disorders. There were no psychotropic medications or advanced diagnostic techniques or readily available follow up. However, there was a raw emotion of pain and suffering with universally shared stressors: every single person I encountered had lost a family member, a friend, a home; all that was left was despair. In response, we performed psychiatry in its purest form. People were encouraged to express their emotions and explore their pain. Beneath the tears and heartache, together we were able to find the hope that everyone still had within them. Giving this back to the people, showing them what they did have left, and helping them move forward was more healing than any suture stitched.

Victims of the earthquake became more than just patients over the first few days: they became part of our team. Volunteer translators from the destroyed neighborhoods were ubiquitous and worked relentlessly. Bridging the gap between our English and their Creole provided them with a purpose that helped heal their wounds. All of them were living outside without reliable access to food or water and had lives to rebuild. Yet, they spent their days helping us help others. One "terp" as the military referred to them, Francillon, thanked us for giving him a way to "help the living go on with their lives rather than dig through the dead that cannot be helped." Francillon was a smart 25-year-old who spoke near perfect English and picked up quickly on the various medical procedures he saw. On our last day he slipped a letter to our team that explained his plight:

"Dear Brothers and Sisters I greet you in the precious name of our Savior and Lord Jesus Christ. It has been so long time ago, since I'm facing the road alone. My father is gone since I was a little boy and my mother can't work to give everything we should need, my mom had four children there's one of us who's not with us anymore, the older, she's gone too. Last Tuesday when the earthquake came, it ruined every thing I had before and now I sleep outside. I completely fear the night when it comes for I don't want to be sick like the others."

This excerpt is representative of the emotions shared by all survivors of the earthquake. To many, the psychological impact was debilitating. It was this internal trauma that is far more difficult to treat than the external lacerations and avulsions. We would spend countless hours listening to everyone's stories and demonstrating that people did care.

The trauma was still so raw and the thought process teetering off the fringe of stability that it would only take one aftershock to reverse all we had done. Analogous to the few unstable buildings still standing that collapsed with the new tremors were the frail minds that finally broke from the stress as the ground shook again. For a time it seemed that nowhere was safe: staying indoors risked death from secondary collapse, outdoors the risk was illness, infection, and violence. Helplessness, however, was relieved by collective support. At night hundreds of people would march past the tent hospitals and sing hymns of prayer for both the injured and ill as well as the providers working to treat them. Mothers who lost their children staffed what are now outdoor orphanages that grew in size every day. Helping others and rebuilding a society became self-medication for acute stress disorder.

Modern Psychiatry struggles with the quantification of its many diagnoses. In attempting to unify the field with more of the definitive diagnostic methods of surgery or medicine it runs the risk of labeling people rather than helping them. Of course, such labels are important to maintain order within the field and useful in guiding treatments and research. However, I learned that sympathy and an ear can placate many. The resilience of people is unquantifiable, and the most important psychiatric tool of compassion is within us all.

Alina Djougarian, SUNY Stony Brook
*Floating Away*